

0303_caEHR SME Meeting -Discussion Notes

Wednesday, March 03, 2010
12:05 PM

Attendees: John, Ray, Ann S., Anna S, Dianne R, Helen S, Bill D, Christine B, Gene K

Review Materials getting ready to go to ballot at HL7



Upcoming Meetings: 3/10, 17, 24, 31

- ☐ Christine will be sending out the invites shortly, and there could be some ad hoc meeting requests or changes to these regularly scheduled meetings, but none known at this point in time.
- ☐ There are some open questions from the technical team members that will be written up and passed along for review and comment from the DE team members.

Discussion Document Displayed


- ☐ DC2.4.4.2 - may not be an issue with the current narrative as previously thought. Helen to review.
- DC1.1.3.1.3 - New questions on requirements from input on the HL7 community
 - Emergency department fed through some feedback to address their needs.
 - Flag that the patient doesn't fall within your criteria, when accepting the referral.
 - System presents the capability to the user to perform triage.
 - We need to be elaborate in our description of the functionality
 - ? Is emergency treatment (emergency room visit) automatically a referral?
 - Point 6- managing patient across two systems.
 - Present a potential for defining the business rules for the specialty that is being provided, and expected system behavior. Can be clinical or administrative rules.
 - ☐ Drive out with a use case.
- DC1.7.2.4 This section is create and sending referrals - the name caused the team to question the description and intent.
 - Helen is unable (constrained) to keep the section names the same
 - 'The system SHOULD maintain a list of providers for referrals' In the supportive section, there is requirements on managing providers.
 - ☐ The system would have another process whereby the provider would accept electronic information or require manual. Line item 347 in FP. Make a note to get clarification.
 - Point #3 - system needs to be able to take the information and populate it in the request. "The system should support the ability to provide..." or should it be "the system shall incorporate the administrative details as necessary into the referral. (Christine made the edits into the document)
 - ☐ Referral is an object.
 - Point #5 - the appt process has been completed. Then other clinical documentation would be keyed. Change wording to...the system should be able to capture the scheduling.
 - ☐ There are often time sensitivities...so the scheduling needs to happen quickly. Removed the word 'completion'
 - Q: If there is a referral spec created from HL7, do we want to put it in our specification and adopt it?
 - A: Yes...using the standard makes the functionality/interfaces more extensible to other vendors.
 - Line number 358 - questions on the word 'correct'. Might it equate to the intended or 'appropriate' provider. Helen asked that it not be changed from correct. John challenges it and doesn't want the system to decide who he is to send to (just offer suggestions of dr.

that is appropriate for the need) , and no substitutions without the providers approval.
What if the DR. is on vacation? Will that be an authorized alternate? Will you want all those decisions for the doc to make? Lot of admin. John would want to see it.

- ☐ Efficiency vs precision?
-  ■ Build use cases around situations where the referral gets direction changed
 - ☐ Line 358 - Candidate for narrative
- Line 641 - Support for Referral Process - clinical and admin/insurance info is combined. All agreed this is ok, but not optimal.
- Line 643 and 645 - are they synonymous? There is a subtle difference, but worthy. Programmers will want to know the nuances.
 - ☐ Why would you include something in a referral but not intend to send it. 'Transmitted' is the key word...there might be some items in #2 that get printed or dealt with outside of a transmission activity.
 - ◆ These items play into the vendor conformance as they may be able to do #2 and not #4.
 -  ◆ Helen to review #2 and #4 to see if consolidation or wording can be managed more clearly and avoid duplication.
- Support for Referral recommendations - (this section is tagged as an optional requirement by the DE team)
- ★ ■ Needs to be reviewed against DC 1.7.2.4 as this conflicts with the referral support.
 - ☐ Reclassify the section to conformance of DC 2.4.4.2 line #647...or leave it as optional and reclassify the conformance criteria from a shall to should(that is line 355 and was changed in the document during the call)

☐

(No break accepted)

- Use Case Review - Referrals
- Displayed 'Receive and Process Patient Referral-Transfer_Care-Episodic' Use Case
 - Reviewed open questions about patient responsibility during referral process.
 - ☐ Referrals typically include a phone call between providers to consent on the referral and that marks the point that the handoff is official.
 - ★ ☐ The responsibility of managing the patients care does not start until the referred patient enters the office of the receiving provider.
 - ☐ Anna offered an informal qualification of a 5-step patient contract criteria;
 1. patient has a problem
 2. patient asks for help from doctor
 3. doctor recommends help
 4. patient takes doctors recommendation
 5. patient (or somebody) pays doctor
 - Transfer of care only occurs in cases where the patient moves and needs to join another practice or similar.
 - In a typical referral for a consultation, you will get a message back
 - Scenario where patient doesn't appear for scheduled visit after referral.
 - ☐ Responsibility of receiving provider to let the referring provider know of patient absence
 - ☐ Responsibility of referring provider to investigate absence of patient at referred site. Court cases on same have held referring provider liable.
 -  ◆ It is helpful for the receiving physician to also investigate potential alternate flows for our receive referral use cases to include no-show or patient opt-out situations

- ◆ (Anna) Optimally, the electronic system would feed through updated information as to why the patient didn't show up or has some new treatment information included for the receiving providers eHR system.
- Scenario where patient does show up at first appointment with receiving provider, but there was some type of medical activity or assessment updates that took place between the referral acceptance and the patient arrival.
 - This information needs to be sent to the receiving provider as an update.
 - ◆ Primary physician(or referring physician) is responsible for providing the updated information.
 - ◆ A common term for this type of update is "Interim Report"
 - ◆ In the example of a patient having chest pain in the middle of the referral process and heading into a bronchoscopy, the receiving physician needs to have that information to properly address the intended care.
 - ◇ Professional courtesy situation
 - ◇ ? An eHR system would need to know that there is an open consult and inform the referring physician(or both?).
 - ◆ Analyst Note: Use case storyboard option
- Generally the information being sent during a referral is the same though there might be some scenarios where additional information is provided.
 - Analyst Note: Address these scenarios with level 2 use cases.
- In a scenario where a patient is referred to a practice with multiple providers, the receiving provider's office will select an appropriate physician for the patient within that practice, and communicate back(to the patient and the referring physician?) of the selection.
 - The physician will always be directing a patient to an individual or a practice (or otherwise stated, to an intended audience) . There is no scenario where the patient would be referred out to a general audience to then be accepted by a listed physician.
 - Analyst Note: Work up a level 2 use case for this scenario
- Analyst note: Explore Care terms in S.1.3.5 of FP & review Activity diagrams that exist for referrals.
- Referral Scheduling -
 - Q: In electronic scheduling exchanges, is there a need for human intervention?
 - A: Generally, yes as the scheduling system interactions are not mature enough to know whether an open slot on a schedule is the time at which the receiving physician takes the type of patient requesting that appointment.
 - Negotiations between providers would be necessary and have any privacy issues worked through.
 - A patient might do the scheduling, but most often it is the providers making those arrangements ahead of the first appt at the referred (or consulting) site.
 - There is very little scheduling requirements in the FP so far, but Helen will explore further.
- ○ Analyst Note: It would be prudent to explore the domain model to extract an understanding of the interaction between referral/consult/transfer of care/medical summaries/discharge summaries/clinical report, consult notes...etc. concepts.

Ref: Discussion Document DC 1.7.4.2